

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN241AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/16/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON GROUP CARE #2</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1240 E 10TH STREET RENO, NV 89512</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments  Surveyor: 25375 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/16/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of A.  The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was six. Six resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed.  The following deficiencies were identified:	Y 000		
Y 105 SS=F	449.200(1)(f) Personnel File - Background Check  NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.176 to 449.185, inclusive.  This Regulation is not met as evidenced by: Surveyor: 25375 Based on record review and interview on	Y 105		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 105	Continued From page 1  11/16/09, the facility failed to ensure 1 of 3 caregivers met background check requirements (Employee #3).  Severity: 2 Scope: 3	Y 105		
Y 178 SS=C	449.209(5) Health and Sanitation-Maintain Int/Ext  NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.  This Regulation is not met as evidenced by: Surveyor: 25375 Based on observation on 11/16/09, the facility failed to ensure debris was not stored on the sides of the house (a large wrinkled rug, furniture in various stages of disrepair and a piles of wood).  Severity: 1 Scope: 3	Y 178		
Y 251 SS=F	449.217(2) Storage of Food-Perishable foods refrigerated  NAC 449.217 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees or less.	Y 251		

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Y 251	Continued From page 2  This Regulation is not met as evidenced by: Surveyor: 25375 Based on observation on 11/16/09, the facility failed to ensure refrigerated foods were kept at a temperature of 40 degrees or less.  Severity: 2 Scope: 3	Y 251		

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